

AMENDMENTS

2010—Pub. L. 111-148, §1563(c)(5), formerly §1562(c)(5), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “and health insurance issuers offering group or individual health insurance coverage” for “health insurance issuers providing health insurance coverage in connection with group health plans”.

EFFECTIVE DATE

Pub. L. 105-277, div. A, §101(f) [title IX, §903(c)(1)], Oct. 21, 1998, 112 Stat. 2681-337, 2681-438, provided that: “(A) IN GENERAL.—The amendment made by subsection (a) [enacting this section] shall apply to group health plans for plan years beginning on or after the date of enactment of this Act [Oct. 21, 1998].

“(B) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by the amendment made by subsection (a) shall not be treated as a termination of such collective bargaining agreement.”

§ 300gg-28. Coverage of dependent students on medically necessary leave of absence

(a) Medically necessary leave of absence

In this section, the term “medically necessary leave of absence” means, with respect to a dependent child described in subsection (b)(2) in connection with a group health plan or individual health insurance coverage, a leave of absence of such child from a postsecondary educational institution (including an institution of higher education as defined in section 1002 of title 20), or any other change in enrollment of such child at such an institution, that—

- (1) commences while such child is suffering from a serious illness or injury;
- (2) is medically necessary; and
- (3) causes such child to lose student status for purposes of coverage under the terms of the plan or coverage.

(b) Requirement to continue coverage

(1) In general

In the case of a dependent child described in paragraph (2), a group health plan, or a health insurance issuer that offers group or individual health insurance coverage, shall not terminate coverage of such child under such plan or health insurance coverage due to a medically necessary leave of absence before the date that is the earlier of—

- (A) the date that is 1 year after the first day of the medically necessary leave of absence; or
- (B) the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

(2) Dependent child described

A dependent child described in this paragraph is, with respect to a group health plan or individual health insurance coverage, a beneficiary under the plan who—

- (A) is a dependent child, under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage; and
- (B) was enrolled in the plan or coverage, on the basis of being a student at a post-

secondary educational institution (as described in subsection (a)), immediately before the first day of the medically necessary leave of absence involved.

(3) Certification by physician

Paragraph (1) shall apply to a group health plan or individual health insurance coverage only if the plan or issuer of the coverage has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described in subsection (a) is medically necessary.

(c) Notice

A group health plan, and a health insurance issuer that offers group or individual health insurance coverage, shall include, with any notice regarding a requirement for certification of student status for coverage under the plan or coverage, a description of the terms of this section for continued coverage during medically necessary leaves of absence. Such description shall be in language which is understandable to the typical plan participant.

(d) No change in benefits

A dependent child whose benefits are continued under this section shall be entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

(e) Continued application in case of changed coverage

If—

- (1) a dependent child of a participant or beneficiary is in a period of coverage under a group health plan or individual health insurance coverage, pursuant to a medically necessary leave of absence of the child described in subsection (b);

(2) the manner in which the participant or beneficiary is covered under the plan changes, whether through a change in health insurance coverage or health insurance issuer, a change between health insurance coverage and self-insured coverage, or otherwise; and

- (3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children,

this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

(July 1, 1944, ch. 373, title XXVII, §2728, formerly §2707, as added Pub. L. 110-381, §2(b)(1), Oct. 9, 2008, 122 Stat. 4083; renumbered §2728 and amended Pub. L. 111-148, title I, §§1001(2), 1563(c)(6), formerly §1562(c)(6), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911.)

CODIFICATION

Section was formerly classified to section 300gg-7 of this title prior to renumbering by Pub. L. 111-148.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111-148, §1563(c)(6)(A), formerly §1562(c)(6)(A), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “individual health insurance coverage” for “health insurance coverage offered in connection with such plan” in introductory provisions.

Subsec. (b)(1). Pub. L. 111-148, §1563(c)(6)(B)(i), formerly §1562(c)(6)(B)(i), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “or a health insurance issuer that offers group or individual health insurance coverage” for “or a health insurance issuer that provides health insurance coverage in connection with a group health plan” in introductory provisions.

Subsec. (b)(2). Pub. L. 111-148, §1563(c)(6)(B)(ii), formerly §1562(c)(6)(B)(ii), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “individual health insurance coverage” for “health insurance coverage offered in connection with the plan” in introductory provisions.

Subsec. (b)(3). Pub. L. 111-148, §1563(c)(6)(B)(iii), formerly §1562(c)(6)(B)(iii), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “individual health insurance coverage” for “health insurance coverage offered by an issuer in connection with such plan”.

Subsec. (c). Pub. L. 111-148, §1563(c)(6)(C), formerly §1562(c)(6)(C), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “health insurance issuer that offers group or individual health insurance coverage” for “health insurance issuer providing health insurance coverage in connection with a group health plan”.

Subsec. (e)(1). Pub. L. 111-148, §1563(c)(6)(D), formerly §1562(c)(6)(D), as renumbered by Pub. L. 111-148, §10107(b)(1), substituted “individual health insurance coverage” for “health insurance coverage offered in connection with such a plan”.

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after the date that is one year after Oct. 9, 2008, and to medically necessary leaves of absence beginning during such plan years, see section 2(d) of Pub. L. 110-381, set out as a note under section 9813 of Title 26, Internal Revenue Code.

PART B—INDIVIDUAL MARKET RULES

SUBPART 1—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

§ 300gg-41. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage

(a) Guaranteed availability

(1) In general

Subject to the succeeding subsections of this section and section 300gg-44 of this title, each health insurance issuer that offers health insurance coverage (as defined in section 300gg-91(b)(1) of this title) in the individual market in a State may not, with respect to an eligible individual (as defined in subsection (b) of this section) desiring to enroll in individual health insurance coverage—

(A) decline to offer such coverage to, or deny enrollment of, such individual; or

(B) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A))¹ with respect to such coverage.

(2) Substitution by State of acceptable alternative mechanism

The requirement of paragraph (1) shall not apply to health insurance coverage offered in

the individual market in a State in which the State is implementing an acceptable alternative mechanism under section 300gg-44 of this title.

(b) “Eligible individual” defined

In this part, the term “eligible individual” means an individual—

(1)(A) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage (as defined in section 2701(c))¹ is 18 or more months and (B) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

(2) who is not eligible for coverage under (A) a group health plan, (B) part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.], or (C) a State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] (or any successor program), and does not have other health insurance coverage;

(3) with respect to whom the most recent coverage within the coverage period described in paragraph (1)(A) was not terminated based on a factor described in paragraph (1) or (2) of section 2712(b)¹ (relating to nonpayment of premiums or fraud);

(4) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

(c) Alternative coverage permitted where no State mechanism

(1) In general

In the case of health insurance coverage offered in the individual market in a State in which the State is not implementing an acceptable alternative mechanism under section 300gg-44 of this title, the health insurance issuer may elect to limit the coverage offered under subsection (a) of this section so long as it offers at least two different policy forms of health insurance coverage both of which—

(A) are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the issuer; and

(B) meet the requirement of paragraph (2) or (3), as elected by the issuer.

For purposes of this subsection, policy forms which have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

(2) Choice of most popular policy forms

The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all such policy forms offered by the issuer in

¹ See References in Text note below.